

PROPOSED PLAN
FOR
RESIDENTIAL CARE
STATE OF MINNESOTA

STATE PLANNING AGENCY

November 14, 1968

Introduction

On October 4, 1967 Governor LeVander made the following charge to the Governor's Council on Health, Welfare and Rehabilitation:

"Finally, but perhaps most importantly, a thorough review of the utilization of our state institutions - particularly for the mentally ill and the mentally retarded. In this review we must consider the new trends and our emphasis in decentralized care, we must recognize the new efforts of private enterprise in caring for the mentally retarded and mentally ill; we must contemplate the impact of new medical approaches to treatment. Then we must determine how to use vacancies in present institutions, whether to build additional facilities and if so, where and what kind."

In response to this charge the staff of the State Planning Agency contracted with the Stanford Research Institute for information and analysis of alternatives relating to the provision of residential care in Minnesota. Subsequently, the staff with the assistance and advice of the Governor's Council on Health, Welfare and Rehabilitation, the Health Planning Task Force, and several subcommittees on Residential Care with representation from the Social Welfare Planning Task Force, the Vocational Rehabilitation Planning Task Force, staff members from State Departments and Agencies, and from voluntary agencies developed the policies and recommendations included in this plan. The plan consists of four parts: statement of responsibility and assumptions, general policy recommendations, specific recommendations related to disability groups including methods of implementation, and finally, recommendations for non-residential care providing program alternatives to residential care.

Responsibility

The State has a responsibility to ensure that residential care is provided for any citizen, who, for reasons of physical or mental disability is not able to reside in his own home. The State discharges this responsibility through one or more devices: the direct provision of services; purchase of services; establishing standards and licensing of facilities, services, and practitioners; control of public funds utilized in providing services and facilities; statutory and administrative regulation of third-party payers for service. The State Departments of Welfare, Health and Education are responsible for ensuring that specific services are delivered.

Assumptions

Residential care provides care on a 24 hour per day basis to an individual in any facility outside of his own home (except acute

hospitals) and provides access to a variety of appropriate therapies. Therefore, it is an expensive kind of care, and one which removes the individual from his own home, separating him from his family and in some instances may even separate him from his own community.

- 1) It is accepted that residential care is necessary for some individuals but is only a part of a continuum of services including prevention, early detection, out-patient care, special education, day care and many other such services.
- 2) It is assumed, on the basis of current trends, that the need for Residential Care programs for those people presently served will decrease in the future with the development of a wide variety of community based non-residential program serving a variety of needs. However, disability groups are being found to need residential care for which the State in the past has not provided.

General Recommendations

A. Residential or Non-Residential Care.

The State should increase the number and variety of non-residential care programs by direct service and by financial incentive, in some cases requiring legislative enactments, with the long-range goal of minimizing the number of persons in any kind of residential care, while maintaining a system of residential care for those who require it.

B. Role of Private Sector and State.

In addition to financing of care and other methods of stimulating program development in the private sector, and standard setting and supervision, the State will continue to develop residential care programs for mentally or physically disabled people, including those who are mentally ill, mentally retarded, alcohol or drug dependent, elderly, physically handicapped. The same standards will be applied to State programs of residential care as are applied *to the programs in the private sector.*

Single Purpose or Multi-Program Residential Care Centers.

The State should develop multi-program regional centers with varying degrees of residential and program specialization on the same campus for dysfunctioning persons not able to be served in community facilities. This does not preclude integration within programs to the degree necessary or desirable, but requires separate program planning. Program standards for the different programs must be developed and adhered to. The development of multi-program facilities must follow the development of staff and program capabilities for each of the disabilities. Such centers should not be limited to present State residential care institutions.

D. Centralized or Decentralized Provision of Care.

The State should develop presently existing institutional campuses into regional centers, utilizing the seven institutions for the mentally ill, plus three institutions for the mentally retarded as regional centers; further the State should judiciously phase out institutions judged to be inappropriately located or obsolete, and make the gradual addition of new regional program centers located more appropriately; for example, in the metropolitan area where the population of need is greatest.

E. Full-Range of Services or Differential Services.

The State will provide residential care of varying levels, and selected differential services dependent on the following variables:

1. The size of the disability group in question

2. The particular treatment requirements of the disabled group
3. The ability of the private sector to adequately provide the services

The extent to which these services will be rendered will also depend upon related federal policies, and the available federal, state and local resources for those services.

F. Community-based (local) and Regional Services.

The State will provide appropriate services at the regional level according to the policies established previously and will encourage and, where appropriate, financially support to the greatest extent possible the establishment of community-based (local) programs by non-profit groups and/or proprietary owners when it appears that community involvement and the development of community services can better serve the needs of the disability group of concern. Standards for licensing of administrators of such programs must be developed. Residential care programs for children must be planned with local school districts as well as local health and welfare personnel.

- G. The Regional Comprehensive Health Planning Council in each region will work with the statutory boards, advisory committees, and individuals in the region including: Regional Coordinating Committees, (Mental Health - Mental Retardation Boards. State Hospital Program Directors, Special Education regional representatives and other appropriate persons for the purpose of planning programs for that region, both residential and non-residential, for all disability groups.

- but H. The State hospital centers will, as a matter of policy, develop affiliated training programs for appropriate college, junior college, vocational school, and graduate students from schools within their region, or located conveniently. Further, that affiliation with the University of Minnesota and appropriate specialists including not limited to medicine, psychology, education, and related therapies be formalized with the State hospital system, and include student training programs.

- I. Research in general should be encouraged as appropriate. However, evaluation of effectiveness of programs and/or services, both new and ongoing, is a specific type of research that is essential.

SPECIFIC RECOMMENDATIONS RELATING TO DISABILITY GROUPS

I. Recommendations relating only to the residential care of the elderly.

1. The residential care of the elderly will continue to be financed by the federal, state and local levels of government as well as by individuals who have the ability to pay, and will continue to be provided principally by the private sector in community-based facilities.

Implementation:

- a. The estimated cost to the State for the 1967-69 biennium for nursing home care is \$20 million
- b. During the 1969-71 biennium increased support of the Department of Public Welfare will be necessary. Estimated at \$13 million for F. Y. 1970 and \$14 million for F. Y. 1971 - Total equals \$27 million for the biennium 1969-71, which is 22% of the total cost; Federal contribution, 56%; County, 22%.

The State residential care centers must provide limited programs of nursing care for residents who are in state residential care for other than nursing reasons and require temporary care, or for those who cannot be placed in private care.

Implementation: The state presently provides this type of care; no change is required.

3. Residential care at clearly defined levels appropriate to the needs of the individual must be provided so that skilled nursing home care is not provided to those who do not require it.

Implementation: Federal regulations have required establishment of levels of nursing care: extended care, skilled nursing care, intermediate care, boarding care. Some cost savings should result because of more appropriate utilization of care programs.

4. Area-wide Comprehensive Health Planning Agencies, where they exist, must develop review criteria and should review and approve the addition of residential care beds within their regions.

Implementation: The State Comprehensive Health Planning Agency must work with area-wide agencies in fulfilling these responsibilities.

II. Recommendations relating only to the residential care of the alcoholic and drug dependent.

1. Acute detoxification of alcoholics should be provided at community hospitals, with effective referral to the treatment program such as those provided at the State regional center and the community mental health center. This will require:

- A. Education of physicians, graduate and undergraduate and of hospital personnel.

Implementation: Through the Minnesota Hospital Association, State Medical Association and the University of Minnesota.

- B. Financial support for the acute care within hospitals.

Implementation: Through changes in hospitalization insurance and whatever federal, state and local sources can be found.

2. The State regional multi-program centers should provide both short-term treatment and long-term care for alcoholic and drug dependent persons. Special expertise in alcohol and drug dependency should be acquired by such centers.

Implementation: Administrative directives by Department of Welfare. Costs will be estimated by each institution.

3. The development of half-way house facilities in the community is to be encouraged.

Implementation: Recent amendments to the Community Mental Health Center Act provide for federal funding of programs for care of alcoholics and drug dependent persons. Local matching should be sought from industry, United Fund and other agencies. Encouragement can be provided through the Council on Alcohol Problems, the Minnesota Commission on Alcohol Problems and associated educational programs.

Recommendations relating only to residential care of the mentally ill.

1. The State will continue to provide care and treatment for the mentally ill in the State hospital multiprogram centers currently providing care. Care programs may also be developed at those centers not presently providing such care. Care provided may be short-term or long-term depending on individual need. Partial hospitalization programs and out-patient services should also be provided.

Implementation: Will be through the Department of Public Welfare.

2. More residential care programs for emotionally disturbed children and adolescents should be developed.

Implementation: Federal funds available through various Education Acts should be fully utilized. State funds necessary to encourage programs needed should be appropriated.

IV. Recommendations relating only to residential care of the mentally retarded.

1. The State shall reimburse the counties for costs of care of the mentally retarded so that consideration of whether care should be provided in a public or private institution will be made on the basis of the needs of the individual rather than relative cost to the county.

Implementation: Initial legislation to establish the principle of state sharing of costs for care in private institutions has been proposed with a minimum estimated cost of \$1.5 million. Rates and fees paid must be approved by the Commissioner of Welfare. Family responsibility for sharing shall be set at the same rate prevailing for state institutions. Legislation to be presented by Department of Public Welfare.



agreed to
support

2. The State will provide residential care and appropriate services to mentally retarded persons from within the region served by the multi-program regional center. Some specialized services may be provided outside the regional center, and services may vary depending on available local community services, other state special services, availability of specialized personnel, etc.



Implementation: A step in developing a program for mentally retarded at Hastings State Hospital has been proposed, calling for facilities for 60 retarded at a cost of \$1.5 million.

3. The State will require an evaluation of the physical, mental and social disability of each individual for whom residential care is sought in a licensed private or state facility.

Implementation: Standards and methods of evaluation shall be developed by the Department of Public Welfare through the cooperative efforts of private and public groups and agencies, including Health, Education, Community Mental Health Centers, and Regional Multi-Program Centers.

what is definition
handicapped child
only physical?

V. Recommendations relating only to residential care of the handicapped child.

1. Hospital care: The following alternatives apply:

Alternative I. The State shall continue to operate a separate institution for orthopedically handicapped children.

why?

a. As a free standing institution at the present site.

or

b. As a free standing institution adjacent to a medical center which offers pediatric services as a part of its program.

or

c. As a free standing institution adjacent to a medical center containing a children's hospital.

or

d. As an integrated program in a medical center as a part of the total pediatric program.

Alternative II. The State shall phase out the direct service program (Gillette State Hospital) for orthopedically handicapped children and continue to provide indirect services for detection and treatment of physically handicapped children through the Crippled Children's Service in the Department of Welfare. Care for those unable to afford it or unable qualify for assistance from other sources shall be paid by the State.

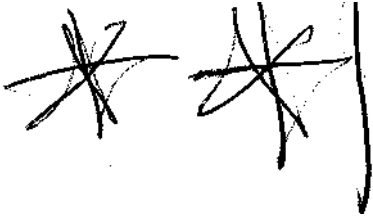
Alternative III. The State shall continue to operate detection and treatment services to the physically handicapped children through Crippled Children's Services. The State shall encourage the development of a new program for residential care and treatment of handicapped children and should subsidize the program associated with a medical center in the Twin Cities Metropolitan area. This new program should offer a full range of services including medical, psychological, rehabilitative and educational programs to those unable to receive care from other sources due to the complex nature of their disability.

2. Local school districts are required to develop special education programs. These may be developed on a multi-district basis if necessary, throughout the state. Planning for these programs may include residential facilities

Pediatric nursing care: convalescent care shall be provided in Convalescent and Nursing Care units or Extended Care Facilities attached to hospitals.

4. Long-term care for those severely handicapped children requiring primarily nursing care shall be made available for children in a wing at a centralized facility in the metropolitan area.

Implementation: Glen Lake-Oak Terrace Nursing Home has competence for this type of care.

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Non-residential Care

Recommendations relating to non-residential care programs. These recommendations are selected on the basis of providing maximum impact on the disability of concern, and minimizing use of residential care facilities where possible.

Elderly

- A. Essential services to the elderly in their homes must be provided throughout the State including:

1. Home health care, as provided by nurses and home health aids through home health care agencies.

Implementation: Currently included in Medical Assistance Program. Financial support from Medicare provides 80% reimbursement. Subsidy required equals \$3000 per county times 87 counties which is \$261,000.

2. Homemaker services to assist in housekeeping tasks.

Implementation: Through County Welfare Departments.

- B. The provision of day care in Nursing Homes for certain of the elderly who do not require 24-hour-a-day care, but would benefit from some supervision, and nutritionally adequate meals, should be considered as an additional service to be provided by licensed Nursing Homes.

Implementation: Eligible for Title 19 payment if classified as Rehabilitation care.
Eligible for Title 3 (Older Americans Act) funding probably a project grant basis.

II. Alcoholic

- A. Community Mental Health Centers should develop programs for information and referral as well as for out-patient treatment of the alcoholic and drug dependent person.

Implementation: Recommendations to Community Mental Health Center Boards.

- B. It is essential that industry provide for early identification and referral of the alcoholic and drug dependent.

Implementation: Commission of Alcohol Problems .

- C. The statutory responsibility for inebriacy rests with the County Welfare Departments. Expertise in alcoholism and drug dependency counseling should be acquired.

Implementation: Through Department of Public Welfare.

- D. Education programs on the problems of abuse of alcohol and drugs should be carried out to prevent alcoholism and drug dependency.

Implementation: Through Commission on Alcohol Problems and Department of Education.

III. Mentally Ill

- A. The major lack in the State is the provision of care for emotionally disturbed children and adolescents, both in-patient and out-patient.

1. The educational responsibilities of the school systems and the treatment role of the Community Mental Health Centers and other treatment resources must be integrated for maximum impact on the emotionally disturbed child

what does integrated mean?

Implementation: Planning within regions to include Boards of Education and Community Mental Health - Mental Retardation Boards.

IV. Mentally Retarded

- A. The State will require special education programs for all mentally retarded children able to benefit from such programs

Implementation: Requires amending State law. Federal funds available. To be presented by Department of Education.

- B. The State will require reporting to the State Department of Education the names of all children who are not being served by the school programs and the reasons they cannot be served. This information is needed to enable those responsible to plan for services for such children.

Implementation: Requires legislation. To be presented by Department of Education. No budgetary request.

- C. The State will increase the support of Daytime Activity Centers for retarded children: pre-school, school age who are unable to benefit from school programs, and post-school.

Implementation: Legislation required: including 1) rent and inclusion, 2) Removal of per capita ceiling.

Estimated cost for biennium - 3.6 million. The Department of Welfare will introduce legislation.

- D. The State will increase support of long-term sheltered workshops for employment of severely handicapped individuals.

Implementation: Requires an appropriation to DVR of 1.6 million dollars.

Things
amortization
of

V. Handicapped Children

- A. Expand detection and treatment program of Crippled Children's Services.

Implementation: State appropriation must be made each biennium to augment the federal funds available but inadequate. Cost estimate for biennium - \$700,000.

- B. Detection and diagnostic programs should be developed within regions as much as possible and coordinated with health department staff, school districts and County Welfare Departments.

Implementation: Administratively through Crippled Childrens' Services.

*even desired public
hospitals in area*